

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/25/2013
NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for one State hospital complaint investigation.</p> <p>Complaint Number: IN 00127851 Unsubstantiated: Lack of sufficient evidence</p> <p>Dates: 6-24-2013 and 6-25-2013</p> <p>Facility Number: 005002</p> <p>Surveyor: Deborah Franco, RN Public Health Nurse Surveyor</p> <p>Methodist Hospitals Inc. was found to be in compliance with 410 IAC 15-1.5-6, Nursing service and 410 IAC 15-1.2-2, Infection control, Hospital Licensure Rules.</p> <p>QA: cloughlin 07/15/13</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1